The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

EVIDENCE OF INSURABILITY INFORMATION

Attach this form with your enrollment card and submit to The Lincoln National Life Insurance Company (herein referred to as "the Company"). Please complete a form for each applicant. No coverage will be effective until approved in writing by the Company. **Complete all blanks in ink and print clearly.** Incomplete forms will cause coverage to be delayed.

Applicant Information:

Name_____ State of Birth_____ Date of Birth____/____/____ Male ☐ Female ☐ Height_____ Weight_____

Relationship to employee_____ Amount Applied For $_____ Total Benefit Amount $_____

Address_____
(Street) (City) (State) (Zip)

Phone Number Home (___)-____-_____ Work (___)-____-_____ Best Time to call_____ Home ☐ Work ☐

Beneficiary (for Life or AD&D Insurance)_____ Relationship_____

Plan Applied for:

Life	☐	Optional Employee Life	☐	Voluntary Employee Life	☐
Dependent Life	☐	Optional Employee AD&D	☐	Voluntary Employee AD&D	☐
STD	☐	Optional STD	☐	Voluntary Spouse Life	☐
LTD	☐	Optional LTD	☐	Voluntary Spouse AD&D	☐
		Optional Spouse Life	☐	Voluntary STD	☐
		Optional Spouse AD&D	☐	Voluntary LTD	☐

Employee Information:

Group Name_____

Name_____ Group Policy Number_____ Group ID_____

Employee Social Security Number_____-_____-_____ Annual Earnings $_____ Date of Hire/Rehire____/____/____

STATEMENT OF HEALTH

	YES	NO
1. In the past 12 months, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?	☐	☐
2. Within the past 7 years, have you ever (a) had, or (b) been told by a physician that you had, or (c) received treatment for a condition listed below? **CIRCLE CONDITIONS ANSWERED YES AND PROVIDE DETAILS BELOW.**		
A. Heart or artery disorder, heart attack, tuberculosis, liver disorder, kidney trouble, lung or other respiratory disorder?	☐	☐
B. High blood pressure? If YES, please note last two readings and date of reading:	☐	☐
Date_____ Reading_____ Date_____ Reading_____		
C. Diabetes? If YES, please note age of onset, and treatment prescribed?	☐	☐
Age at onset:_____ Type of treatment:_____		
D. Cancer, leukemia, malignant growth or any form of tumor?	☐	☐
E. Epilepsy or any mental/nervous disorder?	☐	☐
F. Alcoholism, drug, or substance abuse?	☐	☐
3. Within the past 7 years, have you been diagnosed as having, or been treated for:		
A. Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex), or tested positive for antibodies to HIV (Human Immunodeficiency Virus)?	☐	☐
B. Hepatitis or any sexually transmitted disease?	☐	☐
4. Have you had any physical examinations in the last 5 years? If YES, provide details below and note reason for exam, symptoms, treatment or medication and results.	☐	☐
5. Within the past 5 years, have you had any physical disorder not listed above?	☐	☐

If you answered YES to questions 2-5, please give complete details below:

Item No.	Condition, injury, or findings of exam. If surgery performed, state type.	Date of Onset	Date Last Treated	Results/Degree of Recovery	Name & Address of Attending Physician

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6. Are you:

	YES	NO
A. Under observation or receiving treatment?	☐	☐
B. Taking medication?	☐	☐

If you answered YES to questions 6A or 6B, please provide details below:

Condition	Date of Onset	Name of Medication	Dosage and Frequency	Name and Address of Attending Physician

FRAUD WARNING: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an Insurance Company.

CONTINUED ON NEXT PAGE

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I HEREBY:

1. request the coverage for which I am (or may become) eligible under group policies issued by The Lincoln National Life Insurance Company;
2. authorize any required deductions from my earnings;
3. name the above beneficiary to receive any benefits payable in the event of my death;
4. represent to the best of my knowledge and belief that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed.

I understand that for continued eligibility I must remain an active employee working at least the minimum hours as outlined in the contract.

AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or the Medical Information Bureau (MIB) to release information from the records of:

1. Applicant/Patient Name:_____
(Last) (First) (Middle)

Date of Birth:_____ Social Security Number:_____

This Authorization covers any periods of medical treatment during the last seven years.

2. Information to be released: My complete medical records including:
   - information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
   - prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources.
3. Information is to be released to: EMSI (Examination Management Services Incorporated), The Lincoln National Life Insurance Company or its reinsurers.
4. I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:
   - to reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
   - as otherwise may be required by law or may be further authorized by me.

I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance coverage.

5. I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.
6. I understand that I may revoke this Authorization in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my coverage with the Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
7. A photocopy of this Authorization is to be considered as valid as the original.
8. I acknowledge that I have received the attached Notice of Information Practices.
9. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant:_____ **Date:**_____

Group Insurance Service Office Use: ☐ Self Bill ☐ List Bill

Approved_____ Declined_____

EFFECTIVE DATE:_____

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION

This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance coverage on a fair and equitable basis, we must collect information about you and others for whom coverage may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION

The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. We, or our reinsurers, may make a brief report to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact the MIB at 866 692-6901 (TTY 866 346-3642 for hearing impaired). If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is P. O. Box 105, Essex Station, Boston, MA 02112.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

PERSONAL DISCLOSURE

Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW

After your application has been received in the Group Insurance Service Office, you may receive a telephone call from a specially trained Group Insurance Service Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:
The Lincoln National Life Insurance Company
Group Insurance Service Office
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS